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Dear Provider Task Force Members,

I was initially nominated to be on the Rural Health Task Force and was appointed to the providers instead. They felt that it was important to have a Nurse Practitioner who is a provider in a rural area give input from this perspective. I know that the main charge of our task force is to give input about how the various 4-5 plans will impact providers. But I also felt it was my responsibility as a task force member to share the Providers views. So I went around and discussed Health Care Reform with physicians and nurse practitioners who are Primary Care Providers (PCP's) in the rural Arkansas Valley. They gave me the following thoughts they wanted to share with the legislators and task Force members.

The big concern is the attrition of Primary Care Providers and who's going to take care of the patient's who suddenly have health insurance.
Therefore it seems to me that as the Provider Task Force, we not only give our input about how the plans affect providers, but also suggestions as to how to educate and retain PCPs.

For purposes of this discussion PCPS are defined as Physicians, Nurse Practitioners and Physician's Assistants. There are some who would argue that only Physicians are PCPs but the reality, especially in rural areas and towns 20,000 or less is that N.P.s and P.A.s are providing a lot of care as PCPs. The Staff at the Arkansas Valley Medical Center in LaJunta now consist of 12 primary care physicians, 7 family nurse practitioners and 3 physician's assistants. 20 years ago when I first was on staff at the hospital there were 20 Primary Care Physicians, 2 FNPs and 2 PAs.

The following concerns and suggestions are in a crude format. I would like to see these ideas serve as a PCP Position Paper (OR something similarly named) with the expansion and documentation of ideas by this group and other Provider's. This is IMPORTANT so that the Governor, Legislators and Consumers understand what it is like to "be in the trenches" giving health care.

PROVIDERS IN RURAL AREAS*
PERSPECTIVES ON HEALTH REFORM
*(DEFINED AS CITIES OF 10,000 OR LESS)

IN RURAL AREAS YOU HAVE BASICALLY 3 DIFFERENT KINDS OF PRIMARY CARE PRACTICES.

I. PROVIDERS WHO OWN THEIR OWN PRACTICES AND ARE FOR PROFIT. THEY USUALLY AREN'T ELIGIBLE FOR MANY GRANTS OR PUBLIC MONIES. OFTEN TIMES THEY MAKE LESS MONEY THAN THEIR COUNTERPARTS WHO ARE EMPLOYED BY A NON-PROFIT ENTITY I.E. COMMUNITY HEALTH CLINIC, NON-PROFIT RURAL HEALTH CENTER OR HOSPITALS.

PROVIDERS IN PRIVATE PRACTICE HAVE TRADITIONALLY BEEN THE BACKBONE FOR THE HEALTH CARE IN A COMMUNITY. THEY HAVE MADE A FINANCIAL AND PERSONAL COMMITMENT TO THE COMMUNITY AND OFTERN PRACTICED FOR 20-30 YEARS. THEY PROVIDED CONTINUITY OF CARE FOR THEIR PATIENTS AND THEIR FAMILITES.

IT'S WELL KNOWN THAT OVER THE LAST 30 YEARS THERE HAS BEEN AN EXODUS OF PRIVATE PROVIDERS FROM RURAL AREAS. THE REASONS SIGHTED ARE MANY BUT THE FOLLOWING ARE PROBABLY THE PRIME FACTORS:

--FINANCIALLY THEY CAN'T MAKE THE EQUIVALENT INCOME THAT THEY COULD WORKING FOR A NON-PROFIT PRACTICE THAT OFTEN TIMES RECEIVES PUBLIC MONIES. IN A RURAL AREA A PHYSICIAN IN PRIVATE PRACTICE IS LUCKY TO GROSS 2/3 OF WHAT A NEW FAMILY PHYSICIAN MAKES PLUS THEY WORK 60+ HOURS A WEEK. OFTEN TIMES THEY GIVE AWAY FREE OR REDUCED CARE TO THE UNINSURED OR POOR. RECENT FIGURES TO RECRUIT NEW FAMILY PHYSICIANS ARE $150,000 GUARANTEED SALARY; 3-4 WEEKS PAID VACATION, 1 WEEK CME, AND HEALTH INSURANCE FOR FAMILY, MALPRACTICE, 40-50 HRS. WORK WEEK, HOSPITALIZING PATIENTS IS OPTIONAL. RURAL AREAS ARE COMPETING FOR THE SAME FAMILY PHYSICIAN AS ARE THE CITIES.

--BURN OUT. FINANCIALLY IT IS HARD TO PAY FOR COVERAGE WHEN THEY WOULD LIKE TO LEAVE TOWN. LOCUM TENANTS IS VERY EXPENSIVE. YOU ALSO LOOSE MONEY IF YOU PROVIDE NO COVERAGE. THERE ARE A FEW GRANTS FROM THE MEDICAL SOCIETY (CROP GRANT) THAT MAY HELP PAY SOME OF THE COST. SOME PRIVATE PCPS HAVE GIVEN UP THEIR PRIVATE PRACTICES TO WORK FOR GUARANTEED WAGES FROM NON-PROFIT AGENCIES.

2. COMMUNITY HEALTH CLINICS (CHC) HAVE BEEN THE GOVERNMENT'S ANSWER TO PROVIDING HEALTH CARE FOR NOT ONLY LOW- INCOME PATIENTS BUT ALSO PRIVATE INSURED PATIENTS IN RURAL AREAS. THE PROVIDERS WHO WORK FOR THE CHC OFTEN TIMES ARE THERE TO PAY BACK LOANS OR ARE FOREIGN GRADUATES

ON A J-1 VISA TO BECOME CITIZENS. THE COMMUNITY OFTEN TIMES GETS FRUSTRATED ABOUT CONTINUITY OF CARE DUE TO THE RAPID TURNOVER OF PROVIDERS. THERE PRESENTLY ISN'T ENOUGH FEDERAL FUNDING TO START NEW CHCs IN COMMUNITIES THAT DON'T HAVE A PROVIDER.

3. RURAL HEALTH CLINICS (RHC). THEY CAN EITHER BE OWNED BY A PROVIDER OR A NON-PROFIT ENTITIY. THEY GET BETTER REIMBURSEMENT FOR THE HIGHER POPULATION OF MEDICAID PATIENTS AND MEDICARE. THEY HAVE TO HAVE A NURSE PRACTITONER OR A PHYSICIAN'S ASSISTANT ON THE PREMISES 50% OF THE TIME A CLINIC IS OPEN. THEY HAVE Financially HELPED PROVIDERS IN DESIGNATED PHYSICIAN SHORTAGE AREAS stay in PRACTICE. UNFORTUNATELY IF THEY ARE PRIVATELY OWNED THAN THEY RARELY QUALIFY FOR PUBLIC GRANTS OR MONIES.

THOUGHTS ABOUT WAYS THAT RURAL AREAS CAN RECRUIT AND RETAIN PROVIDERS.

--THERE IS A PUSH TO SPEND A LOT OF MONEY IN TELEMEDICINE THINKING THIS WILL HAVE A BIG IMPACT ON PROVDING HEALTH CARE IN RURAL AREAS. IT HAS BEEN PROVEN FOR MANY YEARS THAT 90% OF THE GENERAL POPULATION'S HEALTH CARE NEEDS CAN BE PROVIDED BY A PRIMARY CARE PROVIDER. THERE ARE A LOT OF UNANSWERED ISSUES WITH TELEMEDICINE AND PROBABLY HAS LIMITED ABILITY TO SOLVE THE PROBLEM OF SHORTAGE OF PROVIDERS. IT WOULD HELP IF THE GOVERNMENT SUBSIDIZED THESE PROVIDERS LIKE THEY DO FARMERS.

--HOME GROWN PROVIDERS ARE A LOT MORE LIKELY TO STAY IN THEIR GEOGRAPHICAL AREA TO PRACTICE. OF THE 7 FNPS AND3 PAS IN THE ARKANSAS VALLEY, THE MAJORITY OF THEM GREW UP IN A RURAL AREA AND PURSUED AN EDUCATION IN HEALTH CARE, EVENTUALLY GOING ON TO FOR MORE EDUCATION AND CHOOSING TO LIVE AND RAISE THEIR FAMILIES IN RURAL AREAS. ALSO SEVERAL OF THE PHYSICIANS GREW UP IN RURAL AREAS.

--THERE SHOULD BE MORE SCHOLORSHIPS TO MEDICAL SCHOOL, NURSING AND NURSE PRACTITIONER SCHOOLS TO LOCAL COLORADO STUDENTS WHO MAKE A 10 YEAR COMMITMENT TO PRACTICING IN A NON-URBAN AREA. THE GOVERNMENT FUNDS FOREIGN STUDENTS IF THEY PRACTICE IN SHORTAGE AREAS SO WHY CAN'T COLORADO?

--ALLOW PROVIDERS IN PRIVATE PRACTICE TO APPLY FOR PUBLIC MONIES AND GRANTS THAT CAN HELP THEIR PRACTICIES STAY IN BUSINESS. (I.E. TOBACCO MONIES TO HELP THEM WITH THEIR UNINSURED POPULATIONS)

--ESTABLISH AT THE UNIVERSITY OF COLORADO HEALTH SCIENCE CENTERS A STRONG PRIMARY CARE OUTREACH PROGRAM. HAVE A SYSTEM WHERE FACULTY OR RETIRED PROVIDERS CAN GO OUT TO RURAL PRACTICES AND PROVIDE RELIEF OR EXTRA HELP IN 1 MONTH BLOCKS OF TIME.

--ESTABLISHEING A REIMBURSEMENT SYSTEM THAT FORCES RURAL PROVIDERS IN PRIVATE PRACTIVE TO DOCUMENT WHETHER THEIR PATITNE CARE IS AVERAGE OR OUTSTANDING IS VERY DIFFICULT. They are SO BUSY SEEING PATIENTS AND DON'T HAVE THE TIME TO DO IT THEM SELVES OR HIRE THE MAN POWER. IT ACTUALLY IS INSULTING TO PROVIDERS THAT THEY HAVE TO DOCUMENT THEIR CARE TO INSURANCE COMPANIES. THEY PRIDE THEMSELVES ON PATIENT CARE, THAT'S WHAT THE MAJORITY OF THEM WENT THROUGH RIGOROUS EDUCATION AND CHOSE THE HEALTH CARE PROFESSION.

--INSURANCE PAPER WORK IN THE FORM OF PRE-AUTHORIZING MEDICATION, DIAGNOSTIC TESTS, AND REFERRALS IS TAKING TOO MUCH OF THE PROVIDERS LIMITED TIME THAT THEY HAVE WITH THEIR PATIENTS. THE COST OF THE EXTRA STAFF TO COMPLY EVENTUALLY TAKES AWAY ANY INCENTIVE.

--DIFFERENT PAYMENT RATES BY DIFFERENT THIRD PARTIES HAS INCREASE COST OF BILLING STAFF. PROVIDERS NEED ONE SIMPLE BILLING FORM TO USE. SAVES COST AND CONFUSION.

AGAIN, THIS IS SOME THOUGHTS FROM OTHER PROVIDERS, PATIENTS AND MY OWN INSIGHTS.. I HOPE THAT THIS GROUP COULD EXPAND ON IT AND WE COULD SEND IT TO THE GOVERNOR, LEGISLATORS AND THE TASK FORCE. I WAS TOLD THAT PROVIDERS HAVE A PERCEPTION OF MYSTIQUE. THEY HAVE BEEN THE DEDICATED PROVIDERS OF THE NATION'S HEALTH. THEY DON'T COMPLAIN MUCH IN PUBLIC AND THEREFORE MANY BLAME THE PROBLEMS WITH OUR HEALTH CARE SYSTEM ON THEM.

SINCERELY,

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